Date: _____

Monroe County ACT Referral
Assertive Community Treatment

REFERRAL FORM: Part I

ACT services are for individuals who are 18 yrs and older, with severe mental illness, (Severe mental illness entails an illness whose symptoms involve either persistent psychotic symptoms or long standing major mood disturbances.) ACT recipients must have a major, non-substance abuse, psychiatric diagnosis as their primary clinical diagnosis and have demonstrated barriers to engaging with traditional, clinic type, mental health services.

Services are specifically for those requiring intensive clinical services or with significant functional impairments directly attributable to their psychiatric illness, as demonstrated by at least three of the following conditions. Please check the items that describe the individual's current risk factors.

A: Current court ordered treatment, such as Assisted Outpatient Treatment (AOT) ☐ or Mental Health Court. ☐

B: Persistent and significant difficulty performing routine activities of daily living, or the ability to perform such tasks only with intensive support from friends or relatives. (Examples of these activities are obtaining medical, legal, and housing services; meeting nutritional needs, and maintaining personal hygiene.) ☐

Please describe:_____

_____

_____

_____

_____

C: Significant and persistent difficulty maintaining employment or carrying out homemaker roles such as preparing meals, washing clothes, budgeting, and child-care. ☐

Please describe:_____

_____

_____

_____

_____

D: Significant and persistent problems maintaining a safe living situation. ☐

Please describe:_____

_____

_____

_____

_____

E: More than two psychiatric admissions within the past year. ☐

Please provide an overall hospitalization history, including dates and locations of most recent hospitalizations:_____

_____

_____

_____

_____

F: Three or more Psychiatric Emergency Room visits in the past year. ☐

Please describe the circumstances:_____

_____

_____

_____

_____

G: Persistent *major* psychiatric symptoms, such as psychosis, significant affective disturbance, or intense suicidality. ☐

Please be specific:_____

_____

_____

_____

_____

H: High risk for, or recent history of, criminal justice involvement as a direct result of the symptoms of their psychiatric diagnosis. ☐

Please be specific:_____

_____

_____

_____

_____

I: History of violent ideation or gesture ☐

Please describe, including significant and persistent triggers, behaviors, and connection to periods of decompensation:_____

_____

_____

_____

_____

J: Residing in an inpatient or supervised community residence, but could live in a more independent living situation if intensive services are provided, *or* they will require residential or inpatient placement unless more intensive services can be provided. ☐

Please be specific:_____

_____

_____

_____

K: Documented and persistent difficulty in effectively using traditional office-based outpatient services. ☐

Please be specific:_____

_____

_____

_____

_____

REFERRAL FORM: Part II

1: Name of individual requiring services: _____	**4:** Your name and your relationship to person needing services (for example, parent, friend, or care manager): Name:_____ Relationship:_____
2: Date of Birth: _____ Gender:_____	**5:** Name of Agency, if mental health professional or other service provider: _____ If you are not the primary treatment provider, you have discussed this referral with them and they are in agreement: ___yes ____no, if no please explain _____
3: Individual's Insurance (if any). *No one will be denied service due to an inability to pay: sliding scale fees are available for individuals without insurance.* _____ MEDICAID#:_____	**6:** Your phone number:_____ Best time to call:_____

7: Current Address (if homeless, indicate where individual might be located—such as a particular drop in shelter or other service provider):
8: Current Phone/Contact Number for Individual:
9: Diagnosis:
10: Current Safety / Violence / Risk Factors. Please include any Risk Assessments if available:
11: Current Community Supports (family, friends, social service agency, job, etc):
12: Legal Concerns:
13: Active Medical Issues:
14: Medication (if on clozapine, please indicate the frequency of blood draws and when next due):
15: Previous treatment experiences, including dates:
16: Note any immediate care management needs:

Date Referral Received by ACT:_____

If possible, please include documentation such as a clinical summary, alerts, risk assessments, medical information, medication administration records, and any recent discharge summaries.

Monroe County has two ACT providers, **Strong Behavioral Health and Rochester Regional Health**. Please check a provider if there is a preference.

☐ **Strong Behavioral Health**
Strong Ties ACT Team
2613 West Henrietta Rd.
Rochester, NY 14623
Telephone: 585-279-4903
Fax: 585-461-9504

☐ **Rochester Regional Health**
Unity ACT Team
89 Genesee St.
Rochester, NY 14611
Telephone: 585-368-3459
Fax: 585-368-3585

Send referral and signed consent to:

Monroe County SPOA (Single Point of Access)
Mo. Co. Office of Mental Health
80 West Main Street, 4th Flr
Rochester, NY 14614
Telephone: 585-753-2874
585-753-2879
FAX: 585-753-2885

Monroe County Office of Mental Health
Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of §33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA)(20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1) I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.

2) The person whose information may be used or disclosed is:

Name:_____. Date of Birth:_____

3) The information that may be used or disclosed includes (check all that apply):

__Mental Health Records
__Alcohol/Drug Records
__School or Education Records
__Health Records
__All of the records listed above

4) This information may be disclosed by:
__Any person or organization that possesses the information to be disclosed
__The persons or organizations listed in Attachment A
__The following persons or organizations that provide services to me:
_____
_____

5) This information may be disclosed to:
__Any person or organization that needs the information to provide service to the person who is subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
__The persons or organizations listed in Attachment A
__The following persons or organizations:
_____
_____

6) The purposes for which this information may be used and disclosed include:

- Evaluation of eligibility to participate in a program supported by the Monroe County of Mental Health;
- Delivery of services, including care coordination and case management;
- Payment for services; and
- Health Care Operations such as quality assurance

Monroe County Office of Mental Health
Permission to Use and Disclose Confidential Information (con't)

7) I understand that New York State and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HERERBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8) This permission expires (check):
__ On this date_____
__Upon the following event_____

9) This permission is limited as follows:
__Permission only applies to records for the following time period:_____to_____
__Other limitations:_____

10) I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

_____ _____
Signature Date

I am the personal representative of the person whose records will be used or disclosed. My relationship is_____. I give permission to use and disclose records as described in this document.

_____ _____
Signature Date

_____
Print Name

Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Monroe County.

Action for a Better Community
Baden Street Settlement
Beacon Health Strategies, LLC
Catholic Family Center
Conifer Park, Inc.
Correctional Medical Services
Daisy Marquis Jones Women's Residence
Delphi Drug & Alcohol Services
DePaul Community Services
East House Corporation
Finger Lakes Developmental Disabilities Services Office (DDSO)
Hillside Family of Agencies
Housing Options Made Easy (HOME)
Huther-Doyle Memorial Institute, Inc.
Ibero-American Action League
John L. Norris ATC
Liberty Resources
Mental Health Association of Rochester
Monroe County Office of Mental Health
Pathways Methadone Maintenance Treatment Program
Pathway Houses of Rochester
Puerto Rican Youth Development
Rochester Regional Health
Rochester Psychiatric Center
Rochester Rehabilitation Center
Syracuse Behavioral Health
Threshold Center
Unity Health System
University of Rochester/Strong Memorial Hospital
YWCA Supportive Living Program
Veteran's Administration
Veteran's Outreach Center
Villa of Hope
Westfall Associates